EXHIBIT 8

FCHR No.: 202231091

FLORIDA COMMISSION ON HUMAN RELATIONS
MEDICAL CERTIFICATION FORM

Aaron Abadi (hereafter "Complainant") has filed a discrimination complaint with the Florida Commission on Human Relations based upon disability. In order to help us conduct our investigation of this complaint, we are requesting certain information from you, as the physician who treats Complainant.

Florida law and the Americans with Disabilities Act define a person with a disability to include: (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; or (3) individuals with a record of such an impairment.

The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance), and alcoholism.

The term "substantially limits" suggests that the limitation is "significant" or "to a large degree."

The term "major life activity" means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, and speaking. This list of major life activities is not exhaustive.

Please answer the following questions:

1. Are you Complainant's treating medical professional with knowledge of Complainant's medical condition and history? ☑YES ☐NO

   If no, there is no need to complete the remainder of this form. Please just sign, date, and return to the Commission.

2. Does Complainant have a physical or mental impairment that substantially limits one or more major life activities? ☑YES ☐NO

   If no, there is no need to complete the remainder of this form. Please just sign, date, and return to the Commission.

FCHR No.: 202231091

3. Please indicate which major life activity is affected and describe how it affects Complainant. Check all that apply.

✓ Breathing: Patient suffers from sensory processing disorder. He cannot tolerate any face covering. If constrained he develops severe anxiety attacks with severe difficulty breathing.

✓ Caring for One's Self: Due to the same reaction, he is unable to function socially & care for himself if under extreme stress.

___ Hearing:

___ Learning:

___ Performing Manual Tasks:

___ Seeing:

___ Speaking:

FCHR No.: 202231091

_____ Walking:

_____

_____

_____ Other: _____

I affirm that the above statements are true.

_____
Signature of Medical Professional

CRISTINA DRAFTA, MD

_____
Printed Name and Title

CRISTINA DRAFTA, MD
301 EAST 17TH ST.
NEW YORK, NY 10003

10/13/2022
_____
Date

Neurology
_____
Area(s) of Specialty